



Certificate of Medical Examination for USMS Employees

Name: _____

District: _____

(Privacy Act Protected)

INSTRUCTIONS

PART I – EMPLOYEE ID DATA

(To be completed by Employee)

Please press firmly to make sure print goes through all pages.

PART II – PHYSICAL REQUIREMENTS OF EMPLOYEES

(To be reviewed by Examining Physician)

PART III – REPORT OF MEDICAL HISTORY

(To be completed by Employee)

Answer all questions and sign your name at the end of the Report of Medical History

PART IV – MEDICAL HISTORY SUMMARY

(To be completed by Examining Physician)

Provide summary and elaboration on all positive answers of the Report of Medical History

PART V – MEDICAL EXAMINATION DATA

(To be completed by Examining Physician)

Perform examination and give a detailed description of your finding(s).

Please note special tests:

1. Vision (required)
2. Hearing (required)
3. Urinalysis (required)
4. SMAC-26 Blood Test (required)
5. Serum Lead Level Test (required)
6. Resting ECG (required)
7. Exercise ECG (if needed)
8. Chest X-ray (if needed)
9. Proctosigmoidoscopy (if needed)
10. Mammography (if needed)
11. Papanicolaou (if needed)

PART VI – EXAMINATION SUMMARY

(To be completed by Examining Physician)

Explain fully any significant findings or limitations and type of followup recommended.

This should include summary of significant lab/test findings.

PART I – EMPLOYEE IDENTIFICATION

NAME (Last, first, middle) (Type or print)	SOCIAL SECURITY NO.	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
DISTRICT ADDRESS			DATE OF EXAMINATION
HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)			
PURPOSE OF EXAMINATION <input type="checkbox"/> Annual <input type="checkbox"/> Biannual	POSITION (Title, Grade)	DATE OF LAST FIT ASSESSMENT	

PART II – PHYSICAL REQUIREMENTS OF EMPLOYEE

• BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO

DEPUTY UNITED STATES MARSHALS ARE REQUIRED TO BE IN SUPERIOR PHYSICAL CONDITION DUE TO STRENUOUS DUTIES. PERSONS IN THESE POSITIONS ARE REQUIRED TO SERVE CIVIL AND CRIMINAL PROCESS, TRANSPORT PRISONERS, MAKE ARRESTS, AND RESTORE ORDER IN RIOT AND MOB SITUATIONS. THEY ARE SUBJECT TO IRREGULAR HOURS, AND ARE EXPOSED TO EXTREME CLIMATIC CONDITIONS FOR LONG PERIODS OF TIME. THEY ARE REQUIRED TO HAVE GOOD VISION AND HEARING, AND BE CAPABLE OF SITTING, WALKING, RUNNING, OR RIDING FOR INDEFINITE PERIODS. THEIR GENERAL PHYSICAL CONDITION MUST IN NO WAY INVOLVE ANY DEFECT WHICH MIGHT BECOME A HAZARD TO THEMSELVES OR OTHERS. DEPUTIES OR APPLICANTS MUST BE MEDICALLY ABLE TO PERFORM EFFICIENTLY AND SAFELY THE FULL RANGE OF DUTIES OF THE POSITION INDICATED BELOW AND STATED IN THE MEDICAL EXAM DATA SECTION.

• FUNCTIONAL REQUIREMENTS

- Heavy lifting, 45 pounds and over
- Heavy carrying, 45 pounds and over
- Reaching above shoulder
- Use of fingers
- Both hands required
- Climbing, use of legs and arms
- Both legs required
- Operation of crane, truck, tractor, or motor vehicle
- Ability for rapid mental and muscular coordination simultaneously
- Ability to use and desirability of using firearms
- Specific visual requirements
 - Both eyes required
 - Depth perception
 - Ability to distinguish basic colors
 - Ability to distinguish shades of colors
- Specific hearing requirements
 - Hearing without aid

• ENVIRONMENTAL FACTORS

- Outside
- Outside and inside
- Excessive heat
- Excessive cold
- Excessive humidity
- Excessive dampness or chilling
- Dry atmospheric conditions
- Working around moving objects or vehicles
- Slippery or uneven walking surfaces
- Unusual fatigue factors
- Working closely with others
- Working alone
- Protracted or irregular hours of work

• FITNESS PROGRAM REQUIREMENTS

EMPLOYEES ARE REQUIRED TO RECEIVE MEDICAL APPROVAL PRIOR TO PARTICIPATING IN THE U.S. MARSHALS SERVICE FITNESS IN TOTAL PROGRAM. PROGRAM CONSISTS OF:

MEDICAL SCREENING

1. Blood lipid analysis
2. Coronary heart disease risk identification
3. Body composition test
4. 3 minute step test
5. Skinfold body fat test

FITNESS ASSESSMENT

1. Flexibility sit and reach test
2. One minute sit up test
3. One minute push up test
4. 1.5 mile run or 3 mile walk

EXERCISE PRESCRIPTION: BASED ON INTEREST AND ASSESSMENT RESULTS

PART III – REPORT OF MEDICAL HISTORY (To be completed by Employee. *Typewrite or print in ink*)

● **STATEMENT OF MEDICATIONS CURRENTLY USED**

Name of Medication	Dosage	Taken Since
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

● **DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN IN PART II?**

☐ YES ☐ NO (If your answer is "YES" explain fully below)

● **HAVE YOU EVER** (Please check at left of each item)

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Lived with anyone who had tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughed up blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Bled excessively after injury or tooth extraction |
| <input type="checkbox"/> | <input type="checkbox"/> | Attempted suicide |
| <input type="checkbox"/> | <input type="checkbox"/> | Been a sleepwalker |

● **DO YOU** (Please check at left of each item)

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses or contact lenses |
| <input type="checkbox"/> | <input type="checkbox"/> | Have vision in both eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear a hearing aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Stutter or stammer habitually |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear a brace or back support |
| <input type="checkbox"/> | <input type="checkbox"/> | Perform aerobic exercise more than 2 days/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke - How much: |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a family history of cardiovascular disease |
| | | Who: |
| | | Problem: |
| | | Age at Onset or Death: |

● **HAVE YOU EVER HAD OR HAVE YOU NOW** (Please check at left of each item)

YES NO DON'T KNOW

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (Check each item) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, erysipelas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen or painful joints |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headache |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear, nose, or throat trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent colds |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe tooth or gum trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or pressure in chest |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Palpitation or pounding heart |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Disease of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Disease of heart |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal chest x-ray |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic or muscular problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased cholesterol level |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in your legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver, or intestinal trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble or gallstones |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to serum, drug, or medicine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, growth, cyst, cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rupture/hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Piles or rectal disease |

YES NO DON'T KNOW

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (Check each item) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal resting ECG |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal stress ECG |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting since age 12 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney stone or blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar or albumin in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VD—Syphilis, gonorrhea, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent gain or loss of weight |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, rheumatism, or bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone, joint or other deformity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lameness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of finger or toe |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful or "trick" shoulder or elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Trick" or locked knee |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis (include infantile) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or fits |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Car, train, sea or air sickness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent trouble sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or excessive worry |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory or amnesia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous trouble of any sort |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Periods of unconsciousness |

● **ARE YOU** (Check one)

☐ Right handed ☐ Left handed

● **FEMALES ONLY: HAVE YOU EVER**

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Been treated for a female disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Had a change in menstrual pattern |

YES NO CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been refused employment or been unable to hold a job or stay in school because of: |
| <input type="checkbox"/> | <input type="checkbox"/> | A. Sensitivity to chemicals, dust, sunlight, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Inability to perform certain motions. |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Inability to assume certain positions. |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Other medical reasons <i>(If yes, give reasons.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for a mental condition? <i>(If yes, specify when, where, and give details.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received psychiatric counseling? <i>(If yes, specify when, where, and give details.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been denied life insurance? <i>(If yes, state reason and give details.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had, or have you been advised to have, any operations? <i>(If yes, describe and give age at which occurred.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been a patient in any type of hospitals? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been rejected for military service because of physical, mental, or other reasons? <i>(If yes, give date and reason for rejection.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been discharged from military service because of physical, mental, or other reasons? <i>(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i> |

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

EXAMINEE	SIGNATURE	DATE
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PART IV – MEDICAL HISTORY SUMMARY (To be completed by Examining Physician)

Note to Examining Physician: Please review this listing with the examinee. Provide summary and elaboration on all positive answers in Report of Medical History. You may develop by interview any additional important medical history and record any significant findings:

EXAMINING PHYSICIAN'S NAME <i>(Type or print)</i>	DATE	SIGNATURE
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PART V – MEDICAL EXAMINATION DATA (To be completed by Examining Physician)

Note to Examining Physician: As you make your examination and report your findings and conclusions please consider the job description, function requirements, environmental factors, fitness program requirements, and medical standards for the U.S. Marshals Service Law Enforcement Position. List any abnormalities under each examination.

• **MEASUREMENTS:**

A. Height: _____ Feet _____ Inches

B. Weight: _____ Pounds

• **VISION:**

STANDARD: Binocular vision is required and uncorrected vision must not test less than 20/200 (Snellen). Corrected vision must test at least 20/20 in one eye and 20/40 in the other. An employee who has undergone a Radial Keratotomy operation to correct his or her distant vision to an acceptable level will not be considered medically qualified for this position. Near vision, corrected or uncorrected, must be sufficient to read Jaeger Type 2 at 14 inches. Ability to distinguish basic as well as shades of color is required as is normal peripheral vision.

EXAM RESULTS:

A. Distant vision (Snellen) 20 20
1. without glasses: right left

2. with glasses, if worn: right 20 left 20
(or contacts)

B. What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type
employees in the Federal classified service as may be required by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

{ without glasses: with glasses, if used:
R. _____ in. to _____ in. R. _____ in. to _____ in.
L. _____ in. to _____ in. L. _____ in. to _____ in.

C. Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO
If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO

• **HEARING**

STANDARD: The deputy or applicant must be able to hear the whispered voice at 15 feet with each ear. Using an audiometer for measurement, there should be no loss of 30 or more decibels in each ear at the 500, 1000, and 2000 Cycles Per Second (CPS) levels. A hearing aid is not permitted.

EXAM RESULTS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)

A. Audiometer (*if available*)

250	500	1000	2000	3000	4000	5000	6000	7000	8000

B. Whispered Voice Test

RIGHT EAR _____ ; LEFT EAR _____
15 ft. 15 ft.

- **CARDIOVASCULAR SYSTEM**

STANDARD: The following conditions are disqualifying: organic heart disease (compensated or not); hypertension (treated) with repeated systolic readings of 160 or over and diastolic readings of 100 or over; symptomatic peripheral vascular disease; and severe varicose veins.

EXAM RESULTS: (*List any abnormalities*)

A. Heart (Size, rate, rhythm, function)

1. Blood Pressure: _____

2. Resting Pulse: _____

3. Resting ECG: _____

4. Exercise ECG (*if needed*) _____

B. Peripheral Blood Vessels:

- **RESPIRATORY SYSTEM**

STANDARD: Any chronic disease or condition affecting the respiratory system which would impair the full performance of duties is disqualifying; e.g., conditions which would result in reduced pulmonary functions, shortness of breath, or painful respiration.

EXAM RESULTS: (*List any abnormalities*)

Chest X-ray (*if needed*): _____

- **GASTROINTESTINAL SYSTEM**

STANDARD: Diseases or conditions of the gastrointestinal tract that require rigid diets are disqualifying. Additionally, an ulcer, (untreated) active within the last year, is also disqualifying.

EXAM RESULTS: (*List any abnormalities*)

Proctosigmoidoscopy (40 years or older): _____

- **GENITOURINARY DISORDERS**

STANDARD: Chronic symptomatic diseases or conditions of the genitourinary tract are disqualifying.

EXAM RESULTS: (List any abnormalities)

Urinalysis: (attach results)

- **NERVOUS SYSTEM**

STANDARD: Deputies must possess emotional and mental stability with no history of a basic personality disorder. Deputies with a history of epilepsy or convulsive disorders must have been seizure free for the past two (2) years without medication.

EXAM RESULTS: (List any abnormalities)

- **ENDOCRINE SYSTEM**

STANDARD: Diabetes not controlled by diet alone is disqualifying.

EXAM RESULTS: (List any abnormalities)

Thyroid: _____

- **SPEECH**

STANDARD: Diseases or conditions resulting in indistinct speech are disqualifying.

EXAM RESULTS: (List any abnormalities)

- **EXTREMITIES & SPINE**

STANDARD: Deformities or diseases of the extremities and spine that interfere with the full performance of position duties are disqualifying. (Position involves heavy lifting and other strenuous duties).

EXAM RESULTS: (List any abnormalities)

Back: _____

- **HERNIAS**

STANDARD: Inguinal and femoral hernias, with or without the use of a truss, are disqualifying. Other hernias are disqualifying if they interfere with the performance of the duties of the position.

EXAM RESULTS: (List any abnormalities)

- **MISCELLANEOUS**

STANDARD: Though not mentioned specifically above, any other disease or condition which interferes with the full performance of position duties is also grounds for medical rejection and the disability retirement process.

EXAM RESULTS: (List any abnormalities)

A. Eyes, ears, nose, and throat (*including teeth and oral hygiene*):

B. Head and back (*including face, hair, and scalp*):

C. Skin and lymph nodes:

D. SMAC-26 Blood test (attach results. List abnormalities):

E. Serum lead level test results (attach results. List abnormalities):

- **FEMALES ONLY**

EXAM RESULTS: (List any abnormalities)

A. Mammography (35 years and older if needed):

B. Papanicolaou test (if needed):

PART VI – EXAMINATION SUMMARY. **Note to Examining Physician:** Summarize below any medical findings which need further medical attention and any finding that would limit the examinee's performance of law enforcement duties or present a hazard to the examinee or others.

• **SIGNIFICANT FINDINGS:**

• **I HAVE EXAMINED THIS EMPLOYEE AND HE OR SHE APPEARS TO BE:**
(Check box(es) that apply)

☐ **FIT FOR DUTY** (no limiting conditions)

☐ **TEMPORARILY UNFIT FOR DUTY** (describe limitations and length of recovery period)

☐ **PERMANENTLY UNFIT FOR DUTY** (explain below)

• **EMPLOYEE IS QUALIFIED TO PERFORM THE FOLLOWING FITNESS PROGRAM ASSESSMENTS:**
(Check yes or no at left of each item):

<input type="checkbox"/> YES <input type="checkbox"/> NO	FLEXIBILITY SIT AND REACH TEST
<input type="checkbox"/> YES <input type="checkbox"/> NO	PUSH-UPS (Max no. in 1 minute)
<input type="checkbox"/> YES <input type="checkbox"/> NO	SIT-UPS (Max no. in 1 minute)
<input type="checkbox"/> YES <input type="checkbox"/> NO	1.5 MILE TIMED RUN
<input type="checkbox"/> YES <input type="checkbox"/> NO	3 MILE TIMED WALK

EXAMINING PHYSICIAN'S NAME (Type or print)	ADDRESS (including ZIP Code)
SIGNATURE OF EXAMINING PHYSICIAN	IMPORTANT: After signing return entire form.